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Review

Beyond burnout: looking deeply into physician distress

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Physician wellness is an important issue and a growing concern within the medical profession. Although "burnout" is a commonly used term to describe physician distress, it fails to capture the many aspects of medicine that negatively impact physician wellness and what physicians experience. In this article, I will explore the personal (unhealthy perfectionism, pathologic altruism, self-recrimination, and the pitfalls of success), interpersonal (empathic distress, moral suffering, bullying, and marginalization), and systemic (medical culture, workplace environment and burnout, and health care system) factors that act interdependently and synergistically to give rise to physician distress. This article is a call for an earnest discussion and for implementing changes by addressing and reconsidering the place of physician wellness in medical practice, education, and research on the one hand, and its impact on patients, families, and society on the other.

In the recently released National Physician Health Survey,[1] physicians in Canada were found to experience high burnout (30%), depression (34%), and lifetime suicidal ideation (19%). Similar findings have been reported repeatedly in the United States and other countries.[2–4] As I reviewed the literature, I found that "physician burnout" has been frequently used as a catchall term. Although it is catchy and helps to increase awareness, this term fails to capture the many complex factors that negatively impact physician wellness, and may actually undermine the ongoing discussion. Why? Burnout is a depleted state characterized by emotional exhaustion, depersonalization, and low personal accomplishment.[5,6] It places the focus or blame on the individual. In response to this "individual" problem, programs such as stress management, resiliency workshops, and mindfulness classes have been offered, but they do not tackle the many structural and organizational factors that require system thinking. On the other hand, although addressing systemic factors is critical, equally important are personal and interpersonal factors that require cultivation of cognitive, affective, and somatic attunement and regulatory skills for oneself and others. Moreover, the distress that many physicians face is not necessarily burnout (i.e., they do not experience emotional exhaustion, depersonalization, or a sense of futility). Instead, what they encounter can be more aptly characterized as empathic distress, moral suffering, or cognitive dissonance as they make difficult decisions that have many consequential trade-offs. Without explicitly naming and addressing these factors, solutions are likely myopic, patchy, and suboptimal. In this article, I will explore the personal, interpersonal, and systemic factors (Fig. 1) that act interdependently and synergistically to give rise to physician distress.

Personal Factors

Although physicians represent a range of personality profiles, they exhibit several common traits.[7] Paradoxically, although these personal characteristics—perfectionism, altruism, exaggerated sense of responsibility, and drive for success—all contribute to a doctor's success, they also come with their own shadow sides: unhealthy perfectionism, pathologic altruism, self-recrimination, and the pitfalls of success.

Perfectionism That Turns into Unhealthy Perfectionism

On the positive side, perfectionism ensures high-quality patient care and is also a quality that is sanctioned by our culture at large. However, being perfect is not always achievable and can become maladaptive. Pressures from the current health care system to do more, quicker, and with fewer resources can make susceptible doctors become obsessive and frustrated people who make seemingly impossible demands on themselves and others. Perfectionism has 3 key components: (*i*) the relentless striving for extremely high standards; (*ii*) judging one's self-worth based largely on one's ability to strive for and achieve such unrelenting standards; and (*iii*) experiencing negative consequences of setting such demanding standards, yet continuing to go for them despite the huge cost.[8] Perfectionistic doctors often struggle with rigidity ("my way is the best way"), inability to delegate

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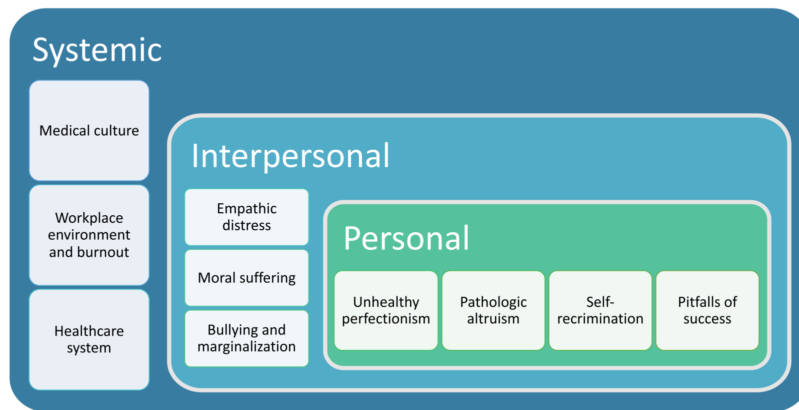

Fig. 1—Personal, interpersonal, and systemic factors that cause physician distress.

tasks ("no one can do it better than me"), tendency to micromanage, and being relentlessly critical of themselves and others.[9] The need for external validation, attention, control, and certainty all contribute to the tendency toward unhealthy perfectionism. Perfectionism has been shown to be a risk factor for anxiety, burnout, and depression,[10–12] as well as hopelessness that has been linked to suicidal ideation.[12]

Beneficence That Slips into Altruism and Pathological Altruism

One of the most fundamental features of medical professionalism is beneficence, a moral obligation to act in the best interest of patients.[13] However, there is a pervasive belief among physicians that professionalism also necessitates altruism. Beneficence and altruism are similar to the extent that both are motivated by concern for others. Yet, beneficence denotes a fiduciary responsibility to patients in a doctor–patient relationship, whereas altruism is directed toward someone to whom one has no such obligation but is instead optional, that is, "beyond the call of duty."[14] What a doctor does routinely on a daily basis, therefore, cannot be called altruistic, because it is within a professional relationship. There are exceptions to this, however; for example, a physician who makes house calls because a patient is too sick to travel acts altruistically because it is beyond the boundaries of professional obligation. Similarly, physicians who join Doctors Without Borders act altruistically as they are not obligated to put themselves in grave danger.

Beneficence and altruism, however, can become unhealthy. Pathological altruism is any behaviour with the motivation to promote the welfare of another, but, instead of beneficial outcomes, leads to negative consequences to the other or even to the self.[15] For example, a doctor who is available 24/7, who treats terminally ill patients aggressively, or who aims to prolong life at all costs can cause immense suffering, and possibly harm, to patients, their families, and other team members.[15] What drives pathological altruism? Fear of humiliation; unconscious need for social approval; a compulsion to fix, save, and help others; a sense of conviction that one's actions are both morally correct and serve an ultimate good; strict adherence to religious rules; empathy-based guilt; and unhealthy power dynamics all contribute to harmful altruism.

Exaggerated Sense of Responsibility That Leads to Self-Recrimination

Professionalism demands a sense of responsibility and ethical conduct, and physicians are expected to be dedicated to their patients. However, physicians are not always responsible for the outcomes of their patients, as many outcomes are not preventable. Indeed, the vast majority of illnesses today (such as diabetes, hypertension, and glaucoma) are chronic. They can be brought "under control" at best, but cannot be cured. In addition, our litigious culture reinforces the idea that someone must be responsible for a bad outcome and hence must be made to pay for it. With a propensity for perfectionism and altruism, some physicians may carry an exaggerated sense of responsibility that can lead to self-recrimination, accompanied by both self-doubt and guilt.

Self-doubt and guilt are highly prevalent among doctors.[7] They often think that they are personally responsible for everything that happens to the patient, overlooking the fact that there are factors that are beyond their control. For example, successful outcomes require collaboration—physicians can only make recommendations, and patients must do their part. In addition, many invasive tests, medical treatments, and surgeries come with risks of complications and mishaps that cannot be completely mitigated. Moreover, the desire to dictate the course of disease or to control a patient's response to treatment often clash with the reality that some illnesses are terminal, giving rise to a sense of impotence. Physicians may nevertheless feel guilty, doubting whether they have made a mistake or a wrong decision, and reproaching themselves for bad outcomes.

Closely linked to self-doubt and perfectionism is the imposter syndrome. It is commonly found in people who "despite their earned degrees, scholastic honours, high achievement on standardized tests, and praise and professional recognition from colleagues and respected authorities, do not experience an internal sense of success."[16] They

often attribute their success to luck or good timing, and have a persistent, often internalized fear of being exposed as a fraud. The imposter syndrome has been found to occur equally among genders and affects clinicians at all career stages.[17] It is a strong predictor of psychological distress and anxiety.[18]

The triad of perfectionism, pathological altruism, and self-recrimination often leads to self-neglect and the lack of self-compassion. Many health care professionals, including doctors, are drawn to the caring professions at least in part because of their own wounds (the "wounded healer" archetype). Their wounds may come from childhood neglect and abuse, parental divorce, significant losses, physical or emotional traumas, poverty, hunger, physical injury and diseases, mental illnesses, addictions, difficult events or situations, betrayals of trust, immigration, or discrimination—in essence, the human condition. The wounded physicians who are self-aware often make good doctors because they can better identify, understand, and empathize with the suffering of their patients—relationships that can be mutually transformative. They recognize that their motivation to care for others arises partly from a need to feel loved and existentially secured. However, if they are not aware of their old wounds and experiences, and "sacrifice" themselves in the name of patient care, they can pay a steep price by neglecting their own needs. They may not eat appropriately, work out, take up a hobby, or spend time for self-reflection, regarding these activities as selfish behaviours. They may handle their anxiety or dejection by working even more, drinking, smoking, or using drugs.[19] This self-neglect and isolation, together with self-recrimination, self-doubt, and guilt, exacerbated by a medical culture that demands stoicism and rationality, makes for an unhealthy mix that, over time, can lead to a dearth of self-compassion that causes immeasurable distress.

Drive for Success and Its Pitfalls

Although doctors generally enter medical school with great empathy, compassion, and idealism, they are not exempt from the larger culture that defines worldly success by how much one acquires, accumulates, and achieves. With their competitive streak and work ethic, many doctors enjoy a successful practice, a prestigious academic title or honour, a high social status, big houses, nice cars, exotic vacations, good looks, or a seemingly perfect family. Even though there is nothing inherently wrong with the rewards that come from their hard work, the pitfalls of success come when maintaining these privileges becomes an obligation, often unconsciously, even as these doctors continue to provide good patient care. At a certain point in time, however, the pursuit of material possessions, pleasures, praises, and recognition makes life feel hollow. For those who are reflective, they may rediscover the true purpose and meaning of their life, and mature to become more conscientious doctors who are no longer driven by the unrealistic idealism of their former youth. For those who are unaware of the perils of these pitfalls, or feel trapped but lack the courage to look deeply or make changes, they may work harder and accumulate more, only to find that the happiness and deep fulfilment that they longed for elusive.

This "seduction" of success is particularly precarious for a small number of doctors who have a narcissistic personality. Although they may seem to have it all, these doctors often do not have a firm core of self-esteem and inner strength, requiring constant reassurance and stroking to feel self-worthy.[19] They may have difficulty seeing how their sense of entitlement gets them into trouble. And when associated with grandiosity and invincibility, they may engage in unprofessional, unethical, or illegal activities, blind to the consequences of their behaviours, and become scornful of their peers who challenge them. Their actions not only cause tremendous suffering to those around them, but also perpetuate their own distress, as no amount of outward achievement can satisfy their fragile egos. Often, when they experience too many simultaneous losses or a setback that is especially humiliating, such as being charged with financial fraud, being fired from a prestigious institution, or being accused of sexual impropriety, these "prominent" physicians spiral downward, succumbing to depression or suicide.[19]

Interpersonal Factors

Empathic Distress

Physicians are expected to be empathetic and compassionate in caring for patients. Empathy has been shown to improve clinical outcomes,[20] patient satisfaction and compliance,[21] as well as physicians' professional satisfaction.[22] Although empathy is trainable,[23] it is often considered a "fluffy" skill in medical education with very little emphasis being placed on its cultivation. It is disheartening to see that numerous studies have shown that empathy decreases during medical school and residency while cynicism increases.[24] Without empathy/compassion training, it is perhaps not surprising that physicians find it challenging to regulate their responses to human suffering, with negative consequences for both patients and physicians.

When doctors encounter a distressing event, such as witnessing the suffering of another or endeavouring to alleviate another's suffering, the emotions they experience depend on their individual attributes. These attributes include the ability to attune to others emotionally (empathy), cognitively (perspective taking), and ethically (moral sensitivity), as well as memory, such as personal and professional experiences, cultural or societal background, personal and familial history, core values, and professional culture (Fig. 2).[25,26] If these attributes are aligned, empathic arousal may evoke a positive emotional response through positive emotion regulation, resulting in healthy empathic concern that leads to compassionate action. When these attributes are not aligned, however, empathic arousal may result in negative emotions, such as sorrow, guilt, regret, frustration, or anger.

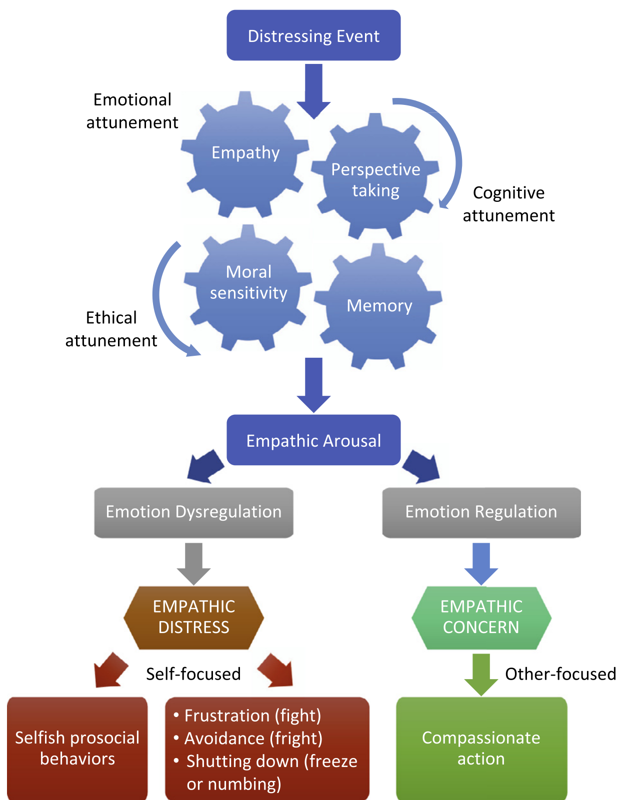

Fig. 2—A model of empathic arousal through emotion regulation that leads to empathic distress versus empathic concern. Modified from Batson et al,[27] Eisenberg et al,[25] Eisenberg,[28] and Rushton et al.[26]

When negative empathic arousal becomes overwhelming, emotional dysregulation may result, leading to empathic distress, an aversive emotional reaction.[25,27,28] To cope with empathic distress, physicians may engage in self-focused behaviours, such as selfish prosocial behaviours that aim primarily to relieve one's own uncomfortable feelings rather than the suffering of another (e.g., rushing to comfort another who is crying). Self-focused behaviours also include fight (e.g., being frustrated or adopting a combative style), flight (e.g., avoiding or abandoning their patients physically, emotionally, or spiritually), and freeze/numbing responses (e.g., shutting down emotionally or adopting a stoic demeanour).

Personal distress may also manifest itself as unregulated actions, including burnout and moral outrage (see next section on moral suffering). Additionally, doctors may suffer in response to repeated exposure or re-exposure to the suffering and trauma of others with their own frame of reference altered, resulting in vicarious trauma.[29] They may also experience symptoms similar to post-traumatic stress disorder without having necessarily been exposed to direct trauma themselves (i.e., secondary traumatic stress). Patients who are difficult, demanding, rude, and unreasonable may also contribute to physician distress.

Moral Suffering

Central to the practice of medicine is the ability to make difficult decisions in the face of ethical dilemmas, yet physicians receive very little education in medical ethics. Without training, physicians may lack moral sensitivity, the ability to recognize morally pertinent features and to identify moral conflicts, as well as moral discernment, that is, the ability to evaluate which actions are morally admissible.[30] When confronted with morally distressing situations, they may become confused, agitated, or frustrated because they lack the vocabulary and training to articulate and process their experience.

Moral suffering is the distress experienced in response to moral harms, wrongs, or failures. It includes moral distress, moral injury, moral outrage, and moral apathy.[30] Moral distress is the experience of knowing the right thing to do but not able to do so because of internal or external constraints,[31] such as when doctors are being compelled to initiate or continue futile life support at a family's insistence, or when doctors discharge patients because of lack of beds despite knowing that the patients will not receive adequate support in the community. Moral distress has been correlated with empathic distress, secondary traumatic stress, and burnout, with the highest level found in physicians in surgery and medical subspecialties compared with those in primary care.[32] These doctors may experience moral remainder, a painful emotional residue that lingers after being forced to choose between 2 or more deeply held beliefs or values.[33]

Moral injury, on the other hand, is a complex psychological, social, cultural, and spiritual injury to an individual's moral conscience resulting from witnessing or participating in an act of perceived moral transgression.[34] It is often associated with shame, guilt, withdrawal, depression, self-loathing, and alienation. For example, physicians may experience moral injury when they provide suboptimal care owing to pressures from administrators or insurers to reduce cost. Physician leaders may experience moral injury when, despite disagreement, they have to carry out administrative decisions or policies that they consider short-sighted, harmful, or in conflict with their personal values.

Physicians may also experience moral outrage—a constellation of cognitive, affective, and behavioural responses—that arises from anger and disgust when one recognizes that a person or institution has violated a moral principle.[35] For example, physicians may become enraged when they witness poor patient care as a result of a lack of provider continuity or team communication. Physician leaders may encounter moral outrage when they deal with peers, hospital administrators, or system bureaucrats who are unprofessional, duplicitous, or incompetent. Principled moral outrage can be beneficial by motivating one to take the right action and bring about changes. However, when it is unexamined or driven by unmet (often unconscious) needs, indignation, or self-righteousness, moral outrage can become contagious,

escalate conflicts, and perpetuate the drama triangle of persecutor, victim, and rescuer.[36]

Opposite to moral outrage, physicians may experience moral apathy when they become indifferent, wilfully disregard, deny, or seal themselves off from the suffering of others or harmful situations,[30] such as when they keep quiet while witnessing others' behaviours that are unsafe, incompetent, or harmful.

From a larger perspective, what is rarely discussed in medicine is the importance of doctors to develop a strong moral character, the ability to attain and maintain moral integrity, and to act in alignment with one's ethical values. It involves having the strength and courage to sustain one's convictions, persisting and overcoming distractions and obstacles, and implementing skills to do the right thing. It arises from training of the mind, emotions, and behaviours that uphold important ethical values. The prevailing bioethics model, however, focuses on adherence to principles—autonomy, justice, beneficence, and nonmaleficence. An important question is: how do we cultivate ethics as a practice to explore and discover our own biases, with the intention to bring about compassion, relationality, moral sensitivity, integrity, patience, trust, humility, and an ability to accept ambivalence?

Bullying and Marginalization

Although many doctors enter the medical profession with the noble intention to serve others, it is perhaps paradoxical to see that their intention extends primarily to their patients and families, but often not to their peers or other health care professionals. Despite their accomplishments, many physicians are very competitive inwardly with their colleagues, but rarely acknowledge this to themselves or anyone. When their peers receive awards, honours, or tributes for their achievements, they may become envious, feeling that the awards given to others make them inferior. They may also be jealous of those who have more successful practices, have larger homes in more coveted neighbourhoods, or take more luxurious family vacations.

Even though this inner competitiveness may often be subtle or benign, on the other end of the spectrum, horizontal hostility (between people of equal rank) and vertical violence (between people of different rank) in the form of bullying are more overt and harmful. Bullying—including rude, ignoring, and humiliating behaviours; yelling; snide comments; and withholding pertinent information—is not uncommon in the medical workplace. In a recent survey of 7887 doctors, 40% reported experiencing bullying.[37] The causes of bullying are many and complex. Doctors, especially trainees, are often reluctant to report incidents of bullying. Many who have been bullied or harassed are often targeted because they are isolated or in a weak position. They fear repercussions and find it difficult to challenge this behaviour as it often comes from the top. To make matters worse, their colleagues do not speak up either, allowing such behaviour to go unchallenged, become normalized, and form part of the culture. This collective silence is further exacerbated by the lack of clarity on what is acceptable behaviour, the lack of commitment or training of departmental heads and managers to handle the problem, and the lack of an effective complaints and resolution process. Unfortunately, ignoring bullying comes at a heavy cost to both individuals and organizations, as well as to patient care and safety (e.g., by withholding needed information or creating an adversarial environment). Those who have been bullied say that they struggled to function, felt physically sick, and felt emotionally broken. It affected their families, destroyed their confidence, and caused lasting harm to their careers.[37]

Although medicine has come a long way in being inclusive of those who have been historically disadvantaged as a result of gender, race, color, religion, sexual orientation, and ability, members of minority groups continue to experience subtle, and sometimes not-so-subtle, forms of marginalization.[7] They often feel discriminated against, trivialized, disenfranchised, or alienated, especially in large medical centres. They may feel less supported, undervalued, or passed over. They may receive comments that are vague, elusive, or contradictory that make them feel uneasy; yet, they may be doubtful or confused by their perceptions because the discriminatory comments are often made unconsciously. It is only when they talk with others who have comparable experiences do they realize that they are not alone and that these messages are real.

Despite a growing number of women physicians, gender gaps in income and advancement opportunities remain across career stages and different areas of medicine.[38] Barriers for women physicians include gender-based discrimination, evaluation biases against women, higher standards set for women, exclusion from male-dominated social networking, lack of women-to-women mentoring, work–life–family balance issues, and hostile work environments.[39] In a recent survey of 1065 physicians, women were more likely to report being humiliated or ridiculed in connection with their work, to have their opinions ignored, to be excluded from conversations, to have information withheld that affects their performance, to have their good work persistently unrecognized, to have someone else taking credit for their work, and to be given unmanageable workloads.[40] Women physicians see more female patients and more patients with complex psychosocial problems, and spend more time on new patients or consultations than their male counterparts.[41] It is no coincidence that women physicians experience higher rates of burnout and depression than men.[1] What is truly alarming in female physicians is their suicide rate. Whereas male physicians have a suicidal rate about 70% higher than men in the general population,

female physicians have a suicidal rate over 250% higher than women in the general population.[42]

Systemic Factors

Medical Culture

Medicine has its own culture with distinct standards of behaviours, evaluation, values, as well as beliefs, myths, and symbols.[43] The medical socialization process begins as one enters medical school, a rite of passage during which one has little control over one's life.[44] Medical students are under enormous pressure to memorize voluminous amounts of information and to master technical skills. When they become residents and fellows, they work long hours, have more responsibility, and fear making mistakes, all exacerbated by sleep deprivation and social isolation. They worry about being humiliated when failing to answer a question at grand rounds, thus feeling ashamed of their imperfect knowledge. They are busy surviving, dealing with multiple competing priorities. They have limited mental resources to reflect on and sustain their personal values and sense of purpose. Yet, these inner resources are crucial not only as they witness human suffering, fear, ambiguity, uncertainty, and death, but also to support their own well-being.

Physicians-in-training also have little time to challenge the legitimacy of what they are learning, or to ponder about the system of power and hierarchy they are experiencing. Whereas the "official curriculum" formally stipulates the set of knowledge and skills required of physicians, the medical culture also strongly influences the values and behaviours of future doctors through unofficial and implicit modes of socialization—the so-called "hidden curriculum."[45] It consists of unexamined practices (e.g., a doctor should not show emotions, especially negative ones); assumptions (e.g., training requires sacrifice); rules (e.g., trainees should just do the work and not complain); protocols (e.g., don't challenge your superiors); power, privileges, and domination (e.g., using pejorative humor toward certain types of patients that one may have deemed offensive before medical school); and indifference to discrimination (detachment from or cynicism toward patients).[43] In the face of hidden curriculum, many trainees feel silenced or powerless when confronted with power hierarchy and unethical, or even harmful, behaviours. The hidden curriculum has also been found to be a main reason for empathy decline during medical school and residency.[24]

With the advent of evidence-based medicine, the practice and teaching of medicine further reinforce a reductionist scientific paradigm at the expense of the cultivation of the values, principles, and practice of caregiving. Evidence-based medicine dismisses intuition and unsystematic clinical experience as valuable tools for clinical decision making, favouring instead the use of biomedical evidence from clinical research.[46] Each patient is reduced to a statistic, without regard to the personhood of the afflicted or his or her condition and struggle. Although both Canada and the United States have recently adopted competency-based models,[47] formal training remains largely dedicated to 2 traditional competencies—medical expert and scholar—with very little curricular time assigned to the 5 so-called "soft skills"—communication, collaboration, leadership, advocacy, and professionalism.[48] Added to the problem is that many physician-educators are not familiar with how to teach or assess these skills. The biggest challenge is: with the current medical philosophy that is predominantly quantitative, empirical, and reductionist, how do we teach and measure qualities such as deep listening, intersubjectivity, human caring, empathy, benevolence, and cultural sensitivity, with all their complexity, richness, and depth?

When young physicians begin independent practice after training, the culture of medicine continues to shape their values and behaviour. Many enter into a "psychology of postponement" by placing the highest priority on establishing their practice, neglecting their primary relationships, and relegating childrearing to one's spouse or a nanny. This postponement, however, may ultimately lead to estrangement and isolation as they find more comfort at work than with the emotional intimacy in their primary relationships at home.[49] "Presenteeism" is also prevalent. Physicians often go to work even when sick because they do not want to let their patients or trainees down. They equate being a patient with being defective and less capable than their peers. They feel that they should be able to self-diagnose or self-medicate, rather than seek professional help. And when they finally do seek help, they worry about the associated stigma, especially with mental health issues. Questions for medical licensing or hospital credentialing such as "Have you ever been treated for alcoholism, drug addiction, or any kind of psychiatric disorder?" further heighten their fear of being "exposed" and losing their hard-earned professional status.[19]

Workplace Environment and Burnout

Many physicians are engaged, are energized, and feel nourished by their work. They have a sense of personal agency and believe that their work makes a difference. Engagement, however, can slip into burnout—a depleted state characterized by emotional exhaustion, depersonalization, and low personal accomplishment.[5,6] What contributes to physician burnout? Whereas many have erroneously asserted that burnout and professional satisfaction are solely the responsibility of the individual physician, many studies have pointed out that the local work environment is a major factor.[50–52] In primary care practices, poor workflow (time pressure and a chaotic and inefficient work environment in which physicians are required inappropriately to perform clerical and other mundane tasks), low work control (over

work conditions and decision making), and unfavourable organizational culture have been found to be strongly associated with low physician satisfaction, high stress, and burnout.[51] For surgical practices, a survey of 7905 surgeons found that factors that are independently associated with burnout include younger age, having children, subspecialty choice, high number of nights on call per week, high hours worked per week, and having compensation based entirely on billing or productivity.[52] Importantly, these studies found that physician satisfaction is linked primarily to their relationship with patients, rather than compensation,[51] and that physicians who spend more than 20% of their time on what they consider the most meaningful activity are least prone to burnout.[53]

The introduction of modern technology—electronic health records, patient portals, and 24/7 remote computer access—promises to lighten physicians' workloads, but the reverse is true. It has been shown that for every hour physicians spent on direct patient care during the clinic day, they spent an additional 2 hours on electronic health records. Outside office hours, physicians spent another 1−2 hours of personal time each night on computer and other clerical work.[54] These unanticipated negative consequences of modern technology are now recognized as a major cause of physician burnout.

In addition to patient care, physicians who work in an academic environment face other challenges. The pressure to teach and supervise trainees, to do research and publish articles, to write and obtain grants, to maintain a laboratory and provide salary support to its staff, to go through academic promotion, and to fulfill administrative duties all contribute to exhaustion, stress, and burnout in academic physicians.[55]

Health Care System

With the health care system burgeoning in both size and complexity, society has also changed its expectations of doctors. Three main changes—asymmetrical rewards, loss of autonomy, and cognitive scarcity—have been identified as adding to physicians distress.[56] Asymmetrical rewards refer to the phenomenon that when doctors do what is expected, they receive little to no recognition, but when they make a mistake, the negative consequences are immediate, painful, and expensive. Their mistakes often become a focus of discussion at Mortality and Morbidity rounds, mandatory public reporting, or the basis of a lawsuit. An error can rapidly eclipse a physician's consistent record of stellar performance, adding to their stress and anxiety.

Physicians are also trained to be autonomous in exercising their judgement regarding how to spend their time, attention, and resources. Their autonomy, however, is in direct conflict with the current practice of managed care with its emphasis on standardized workflows and algorithms, documentation demands, billing rules, as well as intense oversight and control. In the United States, arbitrary regulations, overseen by a mushrooming bureaucracy and third-party payers, now invade every precinct of clinical decisions, from the need for specialist referral to drug prescription and the suitability of hospitalization.[57] Loss of autonomy has been found repeatedly to contribute significantly to physician burnout.[58,59]

Cognitive scarcity refers to the dissonance and dilemma that physicians experience when they have to make decisions that have difficult trade-offs and consequential outcomes (i.e., opportunity costs). In addition to clinical decisions, physicians nowadays also need to evaluate the financial consequences of their decisions on patients and their fiscal responsibility to the health care system as its gatekeepers to ration or deny health care. Evidence has shown that when people have to deliberate on the opportunity costs of each of their decisions, their cognitive performance on logic and problem-solving tasks declines significantly.[60] The current intense focus on economic rationality—with its imperative to contain cost, maximize productivity, and enhance efficiency[61]—is not what physicians are trained in, nor is it what draws them to medicine in the first place. Economic rationality deprives physicians of the moral experience of doctoring—to restore health and alleviate human suffering—that sustains, energizes, and engages them.[62] It is perhaps not surprising that physician burnout, suboptimal care, and decline in humanity and moral value are some of the unintended outcomes of modern health care.

Interdependence of Personal, Interpersonal, and Systemic Factors

It must be emphasized that, although the many factors that contribute to physician distress are described separately, they are interconnected and act in a weblike, nonlinear, synergistic fashion. When we aim at extremely high standards (unhealthy perfectionism), overwork to help others (pathologic altruism), or strive for outward achievement (pitfalls of success), burnout usually follows. When we over-identify with others' suffering (empathic distress), when our integrity is compromised (moral suffering), or when we are subjected to structural violence or systemic oppression (bullying and marginalization), moral suffering or burnout can be the outcome. When our perfectionistic ideals, altruistic actions, or pursuits of success are not aligned with ethical principles, we experience moral suffering. When we fail to challenge the inherent power hierarchy and hidden curriculum in the medical culture, or when the current economic model continues to drive the health care system, depriving the medical profession of its humanity and moral values, moral suffering, a loss of autonomy, or cognitive dissonance ensue.

Call for Action

The many pitfalls and distress that physicians encounter can be looked at as "positive disintegration"[63]—the stress, anxiety, and crises that physicians face are important opportunities for their personal growth, maturation, and transformation. When we find ourselves on the precipice—on the high side of realistic perfectionism, healthy altruism, empathic concern, moral integrity, respect, and wholesome engagement—we can stand firm there and enjoy the panoramic view, recognizing our contribution to humanity, while, at the same time, having the humility to know that we can easily lose balance and fall off the edge.[30] And if we do fall, we can use the fall as a place of transformation where great potential resides. We can work our way back to the high edge skillfully and nonjudgementally, cultivating a wider and more inclusive perspective, developing stronger resilience, and opening the gift of compassion to others and ourselves.

What are some of the skills and changes that allow us to regain and maintain a sense of balance and to stay grounded in the face of the many pitfalls in medicine? At the personal and interpersonal level, cognitive, attentional, affective, and somatic skills stemming from contemplative traditions are particularly useful for the development and maintenance of a sense of resilience and equanimity.[64,65] These skills include awareness practices that help one recognize somatic responses and emotional arousal; mindfulness practices that stabilize attention and emotions; compassion training that primes kindness, generosity, patience, gratitude, and other prosocial attributes; insight practices that develop one's capacity to reflect, inquire, and explore with openness and curiosity; ethics training that fosters one's moral sensitivity, reasoning, and discernment; as well as taking care of basic needs, such as having enough sleep, a balanced diet, regular exercise, and cultivating nourishing relationships that contribute to one's sense of stability, authenticity, and wholeness. Equally important, these personal and interpersonal skills must couple with systems-focused approaches,[66] including interdisciplinary collaboration, conciliation, and system reforms to effect the changes that we desire. It will also serve to remember that system changes sometime require us to take the long view. We can give our best effort, accepting the results without attachment to any preconceived outcomes.

This article is a call for a serious discussion and for taking concrete steps to address physician well-being by reconsidering its place in medical practice, education, and research on the one hand, and its impact on patients, families, and society on the other. By looking deeply into physician distress, we can commence the process of transforming medicine into a healthy system that acknowledges not only the condition, personhood, and struggle of the sick, but also those of physicians. By healing the healers and the health care system, we can return medicine back to its original fundamental core—a deeply interpersonal, relational practice that resonates with both physicians and patients about the joys and pains of living and dying, our common humanity, the purpose and meaning of life, and, ultimately, the true nature of our existence.

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